Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NABIL BISHARA MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-13-3126-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was reduced in error. This claim was for a Division ordered Designated Doctor Exam. We billed a total of $2,350.00 for this claim and were only $1,000.00. The explanation given on the correspondence justifying the denial states: *THIS PROCEDURE IS INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THIS DATE;* however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Worker's Compensation as this services was ordered on the DWC-32.

Therefore, please issue a payment promptly in the amount of $1,350.00 to settle this claim."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "AIG has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position that the bill was paid correctly. The level of service billed for the above date is not reflected by the medical documentation. Please note Rule 134.204 (j) (4) (C) (iv) states, "If the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26". Reimbursement shall be 80 percent of the total MAR. The doctor did not provide any range of motion as reflected in this report. The HCFA did not include the modifier "26"; therefore the bill was paid correctly per the medical documentation."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2013	CPT Code 99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 2 – (97) – The benefit for this service is included in the payment/allowed for another service/procedure that has already been adjudicated
   - 3 – This procedure is included in another procedure performed on this date
   - 4 – This procedure is included in another procedure performed on this date

Issues

1. Is the requestor entitled to reimbursement for the disputed services performed?

Findings

1. Per 28 Texas Administrative Code §134.204 states (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

(1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection.

(3) The following applies for billing and reimbursement of an MMI evaluation.

(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.

(4) The following applies for billing and reimbursement of an IR evaluation.

(A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows.

(I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

(II) If full physical evaluation, with range of motion, is performed:

(-a-) $300 for the first musculoskeletal body area; and

(-b-) $150 for each additional musculoskeletal body area.

Review of the submitted documentation finds that the examining doctor performed services on February 20, 2013 to address the following issues of maximum medical improvement, impairment rating and return to work.

The examination report indicates the following issues mentioned above were addressed. Impairment rating with one body area rated with no mention of range of motion or diagnosis related estimate. However medical bills provided list CPT Code 99456-W5-WP (not in dispute) with one unit in the amount of $950.00, CPT Code 99456-W5-WP with one unit in the amount of $800.00 and CPT Code 99456-W8-RE (not in dispute) with one unit in the amount of $600.00. Requestor billed twice for the same examination. Therefore, CPT Code 99456-W5-WP is not supported. No additional reimbursement recommended.

The respondent issued payment in the amount of $500.00 for CPT Code 99456-W5-WP (not in dispute) and CPT Code 99456-W8-RE in the amount of $500.00 (not in dispute). Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		6/13/14
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.